STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001329	A. BLDG: 00 B. WING:	03/01/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
METRO VASCULAR CARE STATE LICENSE NUMBER: **22371501**	**235 NORTH BROAD STREET, SUITE 100 PHILADELPHIA, PA 19107**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of a State licensure survey conducted on December 16, 2022, at Metro Vascular Center. It was determined the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		
S 033J		S 033J		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 033J	Continued from page 1 553.3 (8)(ii) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: (ii) Applications for positions requiring a licensed person shall be hired only after obtaining verification of their licenses, records of education, and written references. This REGULATION is not met as evidenced by:	S 033J	The Facility Administrator will be responsible for ensuring the completion of this plan of correction. The Facility Administrator will ensure that all licenses have been verified using a primary source verification prior to on boarding of new staff. The Facility Administrator will educate all staff and Human Resources staff on the requirement to perform primary source verification of licenses, prior to hiring new staff. This education will be completed by March 31, 2023. Education will be with an in-service and staff sign-in sheet. Documentation of this education will be provided to the Governing Body. The Facility Administrator will audit all staff personnel files to ensure that all primary source verifications of licenses are present for all licensed staff. This audit will be completed by March 30, 2023 and reported to the Governing Body. To ensure that this deficiency does not recure, the Facility Administrator will audit all staff files monthly for 3 months, ensuring all primary source	Completion Date: **03/30/2023** Status: **APPROVED** Date: **03/27/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 033J	Continued from page 2	S 033J	verifications are present and were completed prior to hiring of new staff. If no deficiencies, then the Facility Administrator will audit all staff files quarterly, as per the Facility QA plan. All audits will be reported to the Governing Body. Any deficiencies will be addressed by the Governing Body.	

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S 033J	Continued from page 3 Based on a review of facility policy, personnel files, and interview with staff (EMP), it was determined the facility failed to verify professional licensure prior to the date of hire for two of two personnel files reviewed (PF4 and PF5). Findings include: A review of facility policy "Compliance Reviews of Clinical Staff Credentials (Pennsylvania)" dated June 1, 2022, revealed "I. Policy. The K&H Medical-Phil PLLC ('K&H') is committed to ensuring that all individuals employed by, or under contract with, K&H have the proper credentials, experience and expertise required to discharge their responsibilities. To this end, K&H is committed to using good faith efforts to not employ or contract with physicians/practitioners or licensed professionals who are not currently licensed and registered with the State... II. Procedures ...A. New Employees/Contractors. Before hiring or retaining any physician/practitioner or other licensed professional, K&H will appropriately query	S 033J		

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S 033J	Continued from page 4 available websites, including, but not limited to... https://www.pals.pa.gov/#/page/search (links to the PA Department of State web page for licensure or certification verification)." A review on December 16, 2022, of PF4, a licensed registered nurse, revealed PF4's date of hire was April 11, 2022. Further review revealed PF4's license was verified on April 19, 2022, after PF4's date of hire. A review on December 16, 2022, of PF5, a licensed registered nurse, revealed PF5's date of hire was June 6, 2022. Further review revealed PF5's license was verified on July 14, 2022, after PF5's date of hire. An interview conducted on December 16, 2022, at 11:24 AM with EMP1 confirmed PF4 and PF5's nursing licensure was not verified prior to hire in accordance with facility policy.	S 033J		

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S 033J	Continued from page 5	S 033J		
S 530A		S 530A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 530A	Continued from page 6 555.3. (a-f) Requirements for membership & privileges a-f § 555.3. Requirements for membership and privileges. (a) To receive favorable recommendation for appointment, or reappointment, members of the medical staff shall always act in a manner consistent with the highest ethical standards and levels of professional competence. (b) Privileges granted shall reflect the results of peer review or utilization review programs, or both, specific to ambulatory surgery. (c) Privileges granted shall be commensurate with an individual ' s qualifications, experience and present capabilities. (d) Granting of clinical privileges shall follow established policies and procedures in the bylaws or similar rules and regulations. The procedures shall provide the following: (1) A written record of the application, which includes the scope of privileges sought and granted. The delineation ' ' clinical privileges ' ' shall address the administration of anesthesia. (2) A review, summarized on record with appropriate documentation, of the qualifications of the applicant. (e) Reappraisal and reappointment shall be required of every member of the	S 530A	The Medical Director will be responsible for ensuring completion of this Plan of Correction. The Medical Director or their designee will edit the Facility's approved procedure list to revise "Supervision of an RN Administering Conscious Sedation" to "Supervision of a CRNA Administering Conscious Sedation". The Medical Director or their designee will edit the Facility's approved procedure list to remove "Arterial Blood Gas Sampling". The Medical Director or their designee will edit the Facility's approved procedure list to remove "Pronounce and Certify Death". The Medical Director or their designee will edit the Facility's approved procedure list to remove "Order restraints per policy". These changes will be made by April 5th, 2023. These changes will be presented to the Governing Body for approval. After approval, the Medical Director or their designee will educate all staff and LIPs on the revised approved procedures list by April 7th, 2023. Education will be with an in-service	Completion Date: **04/07/2023** Status: **APPROVED** Date: **03/27/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 530A	Continued from page 7 medical staff at regular intervals no longer than every 2 years. (f) The governing body shall request and consider reports from the National Practitioner Data Bank on each practitioner who requests privileges. This REGULATION is not met as evidenced by:	S 530A	and staff sign-in sheet. The Medical Director or their designee will also revise the Clinical Privileging Form to reflect the changes made to the Facility's approved procedure list, stated above. All currently privileged providers will have their Clinical Privileging amended to reflect the updated Facility approved procedure list. The Medical Director or their designee will notify all currently privileged providers, in writing, of the changes made to their clinical privileging and request updated signatures on new forms. These notices will be provided by April 7th, 2023. The Facility Administrator will get acknowledgment of receipt of changes from all current providers. All changes, notices, and education will be reported to the Governing Body. Any deficiencies will be addressed by the Governing Body. To ensure that this deficiency does not recure, the Facility Administrator will audit the current provider privileging files to ensure all files have been updated accordingly.	

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S 530A	Continued from page 8 Based on a review of credential files (CF), facility policy, and interview with staff (EMP), it was determined the Governing Body failed to ensure that privileges approved for physicians at the ambulatory surgery center was congruent with the procedures approved by the Governing Body in two of two credential files reviewed (CF1 and CF2). Findings include: A review on December 16, 2022, of CF1, a physician revealed a Clinical Privileges Request form reviewed and approved by the Governing Body on July 22, 2022, for the time period July 18, 2022, to July 18, 2024. Further review revealed "The above-named LIP (licensed independent practitioner) (CF1) is granted clinical privileges commensurate with his or her specialty and commensurate with credentialing policy and procedure. The clinical privileges granted to the LIP are as follows with attached procedure list: Initiate emergency life support...Arterial blood gas sampling... Pronounce and certify death... Order	S 530A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 530A	Continued from page 9 restraints per policy." A review on December 16, 2022, of CF2, a physician revealed a Clinical Privileges Request form reviewed and approved by the Governing Body on June 20, 2022, for the time period of June 20, 2022, to June 20, 2024. Further review revealed "The above-named LIP (CF2) is granted clinical privileges commensurate with his or her specialty and commensurate with credentialing policy and procedure. The clinical privileges granted to the LIP are as follows with attached procedure list: Initiate emergency life support...Supervision of an RN administering conscious sedation... Pronounce and certify death... Order restraints per policy." A review of facility policy "2.05a Approved Procedures" dated August 1, 2022, revealed "Purpose: To establish appropriate and effective services to be provided by the ASC (ambulatory surgery center)." Further review revealed "Initiate emergency life support, Supervision of an RN administering conscious sedation, Arterial blood gas	S 530A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 530A	Continued from page 10 sampling, Pronounce and certify death, Order restraints per policy" was not listed in the policy of approved approved procedures. An interview conducted on December 16, 2022, at 12:05 PM with EMP1 confirmed the clinical privileges granted to CF1 and CF2 incliuding Initiate emergency life support, Supervision of an RN administering conscious sedation, Arterial blood gas sampling, Pronounce and certify death, Order restraints per policy, was not congruent with with the procedures approved approved by the Governing Body.	S 530A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6701		S 6701		

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S 6701	Continued from page 12 567.1 Principle CHAPTER 567 - ENVIRONMENTAL SERVICES 567.1 Principle The ASF shall have a sanitary environment, properly constructed, equipped and maintained to protect surgical patients and ASF personnel from cross-infection and to protect the health and safety of patients. This REGULATION is not met as evidenced by:	S 6701	The Director of Nursing will be responsible for ensuring completion of this Plan of Correction. The Director of Nursing or their designee will educate all Staff and LIPs on the manufacturers instructions for use for the electrodes. This education will include the requirement to mark on the pack, the opened date and discard date. The education will also include the requirement of double folding the top of the opened electrode pack. Education will be with an in-service and staff sign-in sheet. This education will be completed by March 31, 2023. Records of this education will be reported to the Infection Control Committee, which reports to the QA Committee, which reports to the Governing Body. Any deficiencies will be addressed by the Governing Body. Additionally, the Director of Nursing will audit all electrode packs daily for one month, ensuring that the manufacturer's instructions for use are being followed. An audit form will be developed for purposes of tracking the audit. If any	Completion Date: **03/31/2023** Status: **APPROVED** Date: **03/27/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6701	Continued from page 13	S 6701	deficiencies are noted, then the electrodes will be immediately discarded and a new pack of electrodes opened, labeled according to manufacturer's instructions. If no deficiencies, then the Director of Nursing or their designee will audit monthly as part of the facility Infection Control Plan. All audits will be reported to the Infection Control Committee, which reports to the QA Committee, which reports to the Governing Body. Any deficiencies will be addressed by the Governing Body.	

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S 6701	Continued from page 14 Based on a review of manufacturer instructions for use, observation, and interview with staff (EMP), it was determined the facility failed to follow manufacture instructions for use for cardiac electrodes to ensure proper cardiac monitoring for patient safety. Findings include: A review of cardiac electrode brand [XXXX] name redacted, instructions for use revealed "The electrodes stay fresh for 30 days in an open bag, or tray, but up to sixty days if the bag is double folded." An observation on December 16, 2022, at 9:15 AM with EMP2 in pre/post procedure Bay1 revealed an open bag of [XXXX] name redacted cardiac electrodes. Further observation revealed the bag was not folded over and did not contain an open or discard date. An observation on December 16, 2022, at 10:03	S 6701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6701	Continued from page 15 AM with EMP2 in operating room (OR)1 revealed an open bag of [XXXX] name redacted cardiac electrodes. Further observation revealed the bag was not folded over and did not contain an open or discard date. An interview conducted on December 16, 2022, at 10:43 AM with EMP2 confirmed the cardiac electrode package should be double folded and dated with the date opened and discard date to ensure proper cardiac monitoring for patient safety. EMP2 stated "We went through that with staff the other day. Staff are aware they are to write the open date and the discard date. We discard (open packages of electrodes) every 30 days."	S 6701		

Certified End Page

METRO VASCULAR CARE

STATE LICENSE NUMBER: 22371501

SURVEY EXIT DATE: 03/01/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY